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ORIGINAL ARTICLES

OBSERVATIONS ON ACUTE APPENDICITIS.*

By Charles O. Cooke, A. M., M. D.,
Providence, R. I.

Acute appendicitis is not only the most common surgical disease of the abdomen, but it is also one of the most serious. During the past fifteen years no papers on the subject have been presented before this Society. The diagnosis of acute appendicitis should be thoroughly understood by every man in general practice or surgery. At first thought, this statement might seem superfluous, but the increasing number of neglected cases coming under observation, particularly in hospital practice, proves otherwise.

It is hoped that a consideration of this disease today will result in a more careful study of acute abdominal cases and an earlier diagnosis of acute appendicitis. Why is early diagnosis important? Because the mortality is practically nil in cases which are operated upon early in the disease; vice versa, the mortality is high in cases operated upon late. After the infection has invaded the peritoneum and resulted in peritonitis, either localized or general, the disease becomes much more serious and the mortality is high.

Acute appendicitis is at first a local disease because the infection is confined to the appendix itself. Later, the disease spreads to the peritoneum and peritonitis ensues. The peritonitis may localize and an abscess form, or it may progress and a general peritonitis ensue, which is often fatal. If the diagnosis can be made within the first twelve hours of the onset of symptoms, a prompt operation, with removal of the appendix and closure of the incision without drainage, will usually result in a prompt recovery. If, however, peritonitis has set in, the peritoneum must be drained; the patient has not only to fight the effect of the operation, but must also overcome the peritonitis. Often he is unable to do this, and a case dies that might have been saved by earlier diagnosis and earlier operation.

In looking over the histories of a large number of neglected cases, I am convinced that two wrong principles of so-called medical treatment are partly responsible for the errors in diagnosis and the hastening of perforation of the appendix.

The first is the administration of morphine to relieve the initial pain before any diagnosis has been made. Before giving any narcotic, every effort should be made to establish the diagnosis, for as soon as a patient is under the influence of morphine, the symptoms are masked. Spasm and rigidity, very important signs, disappear; the patient feels better, but when seen later in the day, it is impossible to make a diagnosis. In fact, morphine should be withheld until the diagnosis of any acute abdominal case is established and the treatment is decided upon.

The second far too common error in treatment is the administration of cathartics, usually castor oil, calomel, or salts. Any one of these three excites a violent peristalsis and not only tends to spread the infection over the peritoneum, but in many cases actually induces a perforation of the appendix. Many patients attribute the onset of symptoms of acute appendicitis to indigestion following some indiscretion in diet, such as a shore dinner, an extra large meal on a holiday, Thanksgiving or Christmas, or the eating of green apples or mushrooms. Many of them take the cathartic without medical advice; a good many have it prescribed for them. We must, however, refrain from catharsis in any case of suspected acute abdomen until we are sure of our ground.

An unusual case illustrating the effect of delay and neglect was that of a boy seventeen years of age, who entered the Rhode Island Hospital on September 26, 1921, with the following history:

Four weeks previous he began to have pain in the lower right quadrant, accompanied by nausea and vomiting. He was treated for this condition with local applications of ice and poultices. Later the skin over the lower right quadrant of the abdomen and the upper part of the thigh sloughed away, leaving a very foul-smelling, discharging

*Read before the Rhode Island Medical Society, December 1, 1921.

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abscess cavity. Examination showed an extremely emaciated young man who appeared very toxic and was in extremis. The heart was rapid and the sounds were of poor quality. There were moist rales at the base of both lungs. The abdominal wall over a large part of the lower right quadrant had sloughed away, showing a deep abscess cavity filled with thick, greenish, foul pus. Pressure at the right lumbar region and at the right costal margin caused pus to well up in the wound. The skin over the upper anterior and medical aspect of the right thigh had sloughed away, exposing the muscles and the great vessels in Hunter's canal. Probing with a soft rubber catheter showed the abscess cavity to extend upwards to about the costal margin in the anterior axillary line, medially to the median line and laterally, to the lateral abdominal wall and downwards, to the pelvis. The patient died the next morning.

THE DIAGNOSIS OF APPENDICITIS.

In a typical case the symptoms are somewhat as follows: The onset of the disease is almost always ushered in with severe abdominal pain. The diagnosis must be viewed with suspicion if pain is not the first symptom. The patient, previously in good health, is seized with severe adbominal pain, over the whole abdomen. However, the first pain may be referred to the epigastrium or it may be in the appendix region. The pain is usually followed by nausea and vomiting. In a few hours the pain localizes in the right iliac fossa and the patient is exquisitely tender at McBurney's point. The temperature is usually elevated but it may be normal.

The pulse is usually accelerated. There is marked rigidity or spasm of the right rectus muscle. Constipation is usually present, diarrhoea occasionally. Bladder symptoms may be present when the appendix is long and hangs over the brim of the pelvis. The pain and tenderness are occasionally referred to the left iliac fossa or they may be referred high up on the right side when the appendix is retro cecal, extending towards the liver.

Examination of the blood at this time will usually show a marked leucocytosis and an increased percentage of the polynuclear cells. If the resistance of the patient is poor, there will be little or no increase in the number of leucocytes. The polynuclear cells will have been, in my experience, always relatively increased, varying from 80 to 95 per cent. A low leucocyte count and a high relative polynuclear count always indicate a severe lesion and poor prognosis.

The severest types of appendicitis occasionally present the mildest symptoms. It is in these cases that the blood examination is especially valuable. In one case where the symptoms were mild, a leucocyte count showed 9,000 cells. The percentage of polynuclear cells was eighty-six. Operation was performed promptly and the appendix was found ready to rupture and full of pus. In another case, with symptoms suggestive of appendicitis, a normal leucocyte count and a low percentage of polynuclear cells, ruled out an acute inflammatory process and a needless operation was avoided.

We should not neglect the general physical examination. We are often inclined to examine the abdomen alone and to neglect the general examination. Many a case of frank pneumonia has been submitted to needless abdominal operation, due to failure to examine the chest, and not a few cases of gastric crises have been operated upon needlessly, due to failure to examine reflexes. Furthermore, many healthy appendices have been removed, due to failure to examine the urine, which would have given a clue to the presence of a renal calculus or a pyelitis.

The symptoms and signs in acute appendicitis are usually clear and unmistakable. As soon as the diagnosis is established, the appendix should be removed unless there are absolute contra indications. The treatment of the acute appendix is surgical; it is not medical. The infected appendix should be speedily removed. During the first twelve or eighteen hours following the onset of the disease, the abdomen can usually be closed without drainage and the patient will make a prompt recovery. When the peritoneum, however, becomes involved, drainage must be employed. If the patient recovers, convalescence is prolonged; if he does not recover, it is a catastrophe.

During fourteen years of hospital practice, I have had an opportunity to observe and operate upon a large number of cases of acute appendicitis. I have been impressed by the large proportion of cases entering the hospital with well-developed

peritonitis. I think that with a little more study these cases can be recognized earlier and operated upon earlier. The mortality in appendicitis is largely the mortality of delay. As previously stated in this paper, morphine and cathartics are dangerous drugs to use before any diagnosis has been made. Morphine hides symptoms; cathartics encourage perforation of the appendix and the development of peritonitis.

The following case is one which was treated by cathartics, medicine, and delay.

The patient was a woman thirty-one years of age, who was seized four days previously with severe pain in the right lower abdomen and vomiting. A doctor was called, who ordered cathartics and medicine. She continued to grow worse. Three days later she had a sudden attack of sharp abdominal pain, after which she felt better for a time. The following day she was much worse, was distended, cyanotic and in extremis. At this time, she presented the classical picture of general peritonitis and she died in a few hours. The first diagnosis in this case was made four days after the onset of symptoms.

In concluding, I wish to make a plea for a more careful study of all acute abdominal cases. Morphine and cathartics should be avoided. A complete physical examination should be made in every case. The leucocyte count and estimation of the percentage of polynuclear cells is often of great assistance in the diagnosis. As soon as the diagnosis is established in acute appendicitis, the treatment is prompt operation. If doubt exists, the doubt should be cleared up by operation and not by delay. The mortality in acute appendicitis is chiefly the mortality of delay and neglect.

SURGERY IN DIABETICS.*

DR. GEORGE W. GARDNER,
Providence, R. I.

I am to give you my impressions from observation of some diabetics and a study of the records for the past five years at the Rhode Island Hospital.

It must immediately occur to you, as it did to me, that the subject of Surgery in Diabetics must be divided into two classes. The first, to include all surgical conditions not due to the disease, although often much influenced by it; the second, conditions commonly believed to be due to diabetes. In the first class, traumatism and infection. In the second class, carbuncles and gangrene.

While such a division may be of some service and will be used later in the paper, it is but fair to say that it is not a very scientific nor very satisfactory classification, for both carbuncles and gangrene of the second class depend in part, at least, upon infections.

Before taking up the surgical aspects, I wish briefly to state a few facts, or opinions, gained by a study of recent literature. Men, whom we recognize as authorities, differ on many points. While it is true that sugar in the urine is characteristic of diabetes, it is very far indeed from being the only or even the most important characteristic. Sugar is easily detected in the urine and can be greatly diminished by dietetic treatment. But coma, which carries off more than half the cases, is associated with, or caused by, an acidosis apparently independent of the presence of sugar in the urine. In fact, the disease is far from the simple one of earlier teaching, some facts about it are clear but some are obscure and contradictory. The treatment brought out by Allen and developed by Joslin, made easy for the doctor, though often hard for the patient, is now being questioned by other authorities, as discussed by Dr. Fulton in the last number of the *Rhode Island Medical Journal*. Briefly, the latest treatment is avoidance of starvation and under-nourishment by a great increase of fats. However, it was only the other day that we were told to go easy on fats, as increase of fats caused acidosis and coma, and only a little while before this, fats were given without measure—in scriptural terms, fat years are followed by lean.

Again with the giving of alkalies, then you did give them and now you don't. Apparently, if one holds on to discarded treatment long enough he will again be in fashion. It is not at all in my province to discuss these medical questions. Confused and divergent as some of the ideas of treatment are, the fact is undisputed that the medical dietetic treatment has worked well in most cases. The surgeon, however, is interested in the failures, for the failures come his way.

*Read before the Rhode Island Medical Society, December 1, 1921.

I have studied the Rhode Island records for the last five-year period.

I attempted a tabulation and synopsis but soon found that the cases had little in common, and the histories, while probably as full as we would have written them, were very uneven and difficult to use in comparisons.

I offer the following statistics in separate groups with a few explanatory remarks or conclusions at the end of each group of cases:

Surgical conditions complicated by the presence of diabetes. Fractures—Femurs, two, operation none, anesthetic none; one improved, one dead. Humerus, one, operation none, anesthetic none, one dead; Femur and Humerus, one, operation none, anesthetic none, one dead.

Sepsis—Septic hand, one, incision, gas anesthesia, well. Furunculosis, one, incisions, local anesthesia, well. Endometritis, one, curettage, ether anesthesia, improved. Double cataract, one, removal, cocaine anesthesia, improved. Inguinal hernia, one, radical cure, local anesthesia, improved. Single cataract, one, removal, cocaine anesthesia, improved. Cervical abscess, one, incision, local anesthesia, improved.

Surgical conditions complicated by Diabetes—Enlarged prostate, retention, one, catheter and sounds, ether, followed by supra pubic puncture, local anesthesia, dead.

Acute Gangrenous Appendicitis, one, appendectomy, ether, drainage, forced alkalies for days, dead on fourteenth day.

Septic supra pubic sinus, one, incision of abscess, sounds, cocaine, dead.

Strangulated umbilical hernia, one, open reduction, novocaine, dead.

Cystocele rectocele and cervical tears, one, amputation of cervix and repair of perineum, ether, coma, discharged against advice, death imminent.

Out of four fracture cases three deaths from coma within a few hours; of minor surgical cases done under local anesthesia, five cases, four recoveries, one death; of two minor cases done under ether, one recovery, one death; of two major cases done under local anesthesia, one recovery, one death; of two major cases done under ether, two deaths.

I think even this small series helps us to agree with the generally accepted surgical opinion that ether is contra-indicated in diabetes. I have known of several cases of diabetes requiring major surgical operations which recovered and I believe many successfully operated cases at the Rhode Island Hospital were not charted with the associated disease diabetes and, therefore, not found by me. It is human nature to put down every extenuating circumstance in operative failures, and let success through with a careless record. However, it is obvious that diabetes carries a great added risk to any operation, and operations should be done only when imperative.

Statistics on Carbuncle—One case, local anesthesia, dead; two cases, ether, one improved, one dead; four cases, gas oxygen, three improved, one dead; seven cases, four improved, three dead.

It is probable that some cases of carbuncle are not included in this list, especially fatal cases, as only carbuncle cases with sugar in urine were taken, and it often happens that terminal cases of diabetes do not show sugar in the urine. My only observation on carbuncle is, that it is a condition demanding immediate surgical attention. The septic absorption increases the danger. Force fluids, increase carbohydrates, cut down fat, stimulate, and use gas oxygen. Protect patient from needless exposure.

Gangrene of toes or foot—Total number of cases, twenty-five, number of cases not operated on, eleven; of this number six died, two discharged against advice, presumably to die; two local condition improved, one locally healed.

Number of cases toe amputation, four; three cases discharged against advice, presumably to die; one case discharged to medical service, later operated, was the one case locally healed. Number of cases foot amputation, two; both had gas oxygen, both died.

Number of cases lower leg amputation, four; three died, one with ether, two with gas oxygen; one case healed, gas oxygen given.

Number of cases thigh amputation, four; all had gas oxygen; three died, one discharged against advice, presumably to die.

Twenty-five cases, fourteen deaths, six discharged against advice, clearly according to history, in coma, and about to die, two improved and kept on a diet, and three locally healed.

The cases varied greatly in many ways: Some had been under dietetic treatment, some were of

short duration, some of long standing with great amount of sepsis. In the series we had 8% definite improvement, and 12% local cure, but the startling figure of 80% mortality stands.

It thus appears, that under whatever treatment employed, gangrene must be recognized as a terminal condition.

I believe the only possible betterment of these statistics can come by a closer association of medical and surgical services.

While I have felt that a thigh amputation offered the best chance, I think now from a study of these records that careful antiseptic treatment of the gangrene and close attention to the diet, checked up by careful laboratory work, with as little surgery as possible, offers a lesser risk. In any case, it is an almost hopeless situation.

THYROID DISEASE AND ITS TREATMENT.*

DR. FRANK H. LAHEY,
Boston.

It is no less true with thyroid conditions than with other diseases that a correct grouping is essential before adequate treatment can be assigned. And with this in mind it may be wise for me to go over the clinical classification of thyroid disease as employed by us and specify what, in our opinion, are the indications for operation in each group.

In adolescent goitre, the slight symmetrical enlargement occurring for the most part in the isthmus and appearing in young girls at or soon after the establishment of the menses, we have not found that there has been a need for any treatment. The prominence of the isthmus, if it is a true increase in size and not the result of a thin neck, disappears as the girl increases in age and acquires a somewhat greater increase in subcutaneous fat. We have tried iodine in the form of sodium iodide, syrup of hydriodic acid, and potassium iodide, and have not noticed any appreciable change in size. This is a different type of goitre from the colloid adolescent goitre seen in goitre belts and responding to the sodium iodide prophylaxis of Kimball and Marine.

We have occasionally had diagnostic difficulties in this group of pubescent cases when the slight enlargement has been associated with a tachycardia without other signs indicating the presence of hyperthyroidism. This has occurred several times in our experience and has made the decision as to whether the tachycardia was of thyroid or non-thyroid origin quite difficult. In such a case we have insisted that the patient report for a series of metabolism tests some days apart, in order that we might determine from several tests whether the trend of the basal metabolism was along a high or normal level. In addition, we have insisted upon the coöperation of the cardiologist associated with our thyroid group, in order to rule out, if possible, the tachycardias of non-thyroid origin. It has been our experience that when a persistent tachycardia is of thyroid origin, the confirmatory signs, such as staring, loss of weight, myaesthenia, tremor, or nervousness are rarely absent and that when such a tachycardia is present without these signs, even though there be a slight goitre or even a moderately increased basal metabolism rate, one should be extremely cautious in attributing the tachycardia to hyperthyroidism. We feel certain that some of the non-successes ascribed to surgery must be due to a too hasty decision that a persistent tachycardia is the result of thyroid disease. It is in these doubtful cases that delay and deliberation are justly rewarded. We have seen a great many cases of goitre without hyperthyroidism. We have also seen a great many cases of hyperthyroidism with little or no goitre. Likewise, we have seen many cases with increases in basal metabolism, even with tachycardia, in which no hyperthyroidism was present. Conversely, however, we have never seen cases of hyperthyroidism in which both tachycardia† and increases in basal metabolism were not present.

Cysts and adenomata we have operated upon for one or more of the following reasons: When they are unsightly; when they have, or threaten to, become intrathoracic in location; when they are producing pressure; and in adenomata, when they are causing secondary hyperthyroidism. In adenomata, further, we believe that as patients approach the age in which the incidence of malignancy increases, removal should be advised because of the possibility of this complication.

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†Unless examined during and after a considerable period of rest in bed.

It has been our conclusion, after dealing with a great many cases of adenomata of the thyroid, that the possibility of intrathoracic location of adenomata has by no means been appreciated by those whose practice is not of the type to provide a great variety of thyroid lesions, and that in all cases of intermittent attacks of respiratory difficulty the question of intrathoracic goitre should be determined by X-ray.

We have operated upon colloid goitres when they have, or threatened to, become intrathoracic in location—and a great many do; and when they have been associated with hyperthyroidism.

Malignancy of the thyroid in our experience has been an extremely depressing phase of thyroid disease. The only light we are able to see in connection with this almost hopeless group of cases is in removal while still in the precancerous stages of the adenomatous goitres which are present in patients in or approaching the cancer age. Our experience has been similar to that in other clinics, in that we have seen malignant disease appear only in those thyroids which have been goiterous for some time.

We have, with the exception of the X-ray clinic at the City Hospital, where X-ray treatment is being carried out, submitted all cases of hyperthyroidism of any marked degree of toxicity to surgery, the eventual aim of which was the removal of a large proportion—four-fifths or more—of the entire gland. We have been led to pursue this course, first, because the mortality had always been within reasonable limits, 2.5%, in the entire series, 1.28% in this year's series; and, second, because we feel that in our hands it has proved the measure which most certainly, most completely, most permanently, and most quickly produces relief in this group of cases. We know that certain cases of hyperthyroidism present remissions which are permanent in character, and we believe that all that may be accomplished by medical treatment consists of prolonged rest, first, with the purpose of protecting the patient from such injurious effects of loss of metabolism balance as are more obvious and more apt to occur in patients up and about; and, second, with the hope that a period of remission will occur while at rest and prolong itself into a permanent remission.

Against this course are the relatively small number of cases obtaining a permanent remission, the fact that many become poorer operative risks, the small but certain number of deaths that may be attributed to this delay, and the undesirable consequences of prolonging the period during which the organism suffers the effects of the intoxication.

Regarding X-ray treatment, we feel that any measure assuming the attitude of a rival to surgery, since the latter has been generally accepted as the most satisfactory method of treatment in hyperthyroidism, should be readily capable of demonstration of its value. We feel, further, for the purposes of personal conviction and with no reflection on the clinics where X-ray is deemed a satisfactory measure, that its value should be demonstrable in a clinic under our management where the selection of cases is ours and where the interpretation as to cure or relief is also ours.

For this purpose, about eighteen months ago we established at the Boston City Hospital a thyroid clinic, where cases of hyperthyroidism are treated only by means of X-ray. In this clinic we have yet to see a case which even approaches the completeness of the relief accomplished by surgery. To be sure, our cases have been limited in number. A great many cases have been sent for treatment which were not cases of hyperthyroidism, and every precaution has been taken to eliminate every case which did not belong unquestionably under the head of hyperthyroidism. A sufficient number have been treated, however, so that at least a few striking results should have been obtained. In fairness to X-ray, it should be said that a larger series of cases should be treated before a final decision as the result of this study is reached. Further, that we, as clinicians, not as trained Roentgenologists, have no check upon the dosage being used. However, in this direction, we have every confidence of the accuracy of dosage, as the treatment is conducted by a Roentgenologist trained in the X-ray clinic at the Massachusetts General Hospital. In addition, we have submitted to the Roentgenologist a few cases of incomplete cures following surgical removal, particularly where too little had been removed and hypertrophy of the small remaining segment had occurred, and in none of these cases has relief been accomplished by X-ray, while very prompt relief has resulted from the removal of a considerable portion of the remaining segment.

Because of the above-mentioned reasons, therefore, it is our conviction that surgery, with its proved efficacy should be the accepted method of treatment in any thyroid clinic dealing with thyroid cases in large numbers, and that X-ray treatment should be reserved largely for an experimental clinic such as that which we are maintaining at the City Hospital.

We have operated upon a number of cases which have received many X-ray treatments, and we cannot see that they increase the difficulty of the operation.

We have now made over one thousand metabolism tests on over five hundred patients, each operated case having a metabolism test previous to each operative procedure and, if possible, one every two weeks between operative procedures if the poles have been ligated, while, furthermore, all patients showing increase in rate before operation have had their metabolism estimated before leaving the hospital. After leaving the hospital, all toxic cases have returned in two months for another test and in six months for still another one, in order that a control may be maintained on them. While all of the material accumulated as the result of this work has as yet not been completely grouped and studied, there are certain facts which have impressed us as being probably acceptable. The first and most important one, in our opinion, is that hyperthyroidism has not occurred in this group without an increase in basal metabolism rate, and we feel strongly that operations undertaken upon patients with normal metabolisms will yield consistently poor results, since in most of the cases the symptoms will not have been of thyroid origin; second, that there are many borderline cases of neuroses closely simulating but not actually presenting hyperthyroidism, particularly those cases having associated tachycardias.

In this group repeated metabolism estimations should be made. In a majority of these cases the metabolism estimations will be found to be within or approximating normal limits, and in the remainder, even though the metabolism be increased (it will rarely run above +25 in cases of this type) decision in favor of hyperthyroidism should not be made unless very characteristic clinical signs are present as confirmatory evidence. We are certain from experience based upon constant reference of this condition to us that there are today literally hundreds of cases of neuroses under treatment for hyperthyroidism, many of whom are doubtless being operated upon.

As the result of the study of this material, we are convinced that basal metabolism tests properly conducted represent approximately the degree of toxicity of the disease. We cannot subscribe to any statement that it accurately represents toxicity, first, because as yet the method and process of intoxication is not determined, and, second, because the only two methods of gauging toxicity at present are the effects of the condition on the one hand upon the metabolism, and on the other, upon the patient's organism, and unfortunately they sometimes do not check accurately, for now and then we see patients who are clinically quite toxic, yet have but moderately increased metabolism rates; likewise, the reverse has also been true occasionally.

Following ligation of poles, it has been the rule to see a drop in pulse rate, a gain in weight, and a fall in metabolism rate. In a not inconsiderable number of cases we have seen a drop in pulse rate, a gain in weight, a general clinical improvement, but a rise in metabolism rate. We were much disturbed by this at first, but where the clinical improvement has been obvious, the cases have endured well the final procedure of partial thyroidectomy. We are, however, as yet at a loss to explain this apparent inconsistency to our satisfaction.

The drop in metabolism following partial thyroidectomy has been consistent and certain. An investigation of the pre- and post-operative metabolism rate in the last one hundred thyroidectomized cases of primary hyperthyroidism, the last test being made within an average of ten days after the partial thyroidectomy, showed an average drop of 66%. Many cases, however, do not completely reach normal until a few weeks after leaving the hospital, and it has been our experience that in those cases persisting with moderate increases in metabolism rate, moderate symptoms of hyperthyroidism still persist because sufficient thyroid tissue has not been removed, and a further drop can be accomplished by further removal.

Finally, as the result of our experience with the metabolism test in this disease, we are sure that it is a very grave error to consider thyroid disease in terms of increased metabolism and that such a

test can be of as much harm as good unless carefully weighed and co-related with the history and clinical signs presented by the individual.

In the past year and a half we have had Dr. Burton Hamilton associated with us in the thyroid clinic in an attempt to obtain some accurate knowledge of thyroid hearts; at our request he has submitted the following short résumé as the result of his observations on the cases in our clinic for those eighteen months.

Hearts in hyperthyroidism fall into two classes. There are very few intermediate cases. The larger class shows no signs on clinical examination, or in graphic tracings, of heart damage. Patients of all degrees of toxicity (up to death), and of short and long duration of their hyperthyroidism, are in this class. Nor has heart failure occurred here. In fact, if these patients are cured of hyperthyroidism, they are left with sound hearts, so far as can be told.

The smaller class shows definite heart damage, with occurrences of heart failure. Auricular fibrillation appears here, a condition that can always be improved by digitalization. In our clinic 25% of such cases in the last eighteen months have been cured of auricular fibrillation after operation and digitalization. On the other hand, we see no reason for digitalization of hyperthyroidism cases that do not have auricular fibrillation.

For the purpose of reporting immediate statistics of the clinic, this year's cases have been taken. Since January 1, 1921, up to today, 313 thyroid operations have been done. Ligations of one or both superior poles have been done 58 times, with one death. Ligations of one or both inferior thyroid arteries behind the internal jugular and on the inner border of the scalenus anticus has been done 12 times, with no deaths. Injection of boiling water has been made 20 times with no deaths, and 223 operations directly upon the thyroid have been done. Twelve have been hemithyroidectomies on patients deemed too toxic to endure the complete operation. Of these, ten represent two operations on five patients, each having had two hemithyroidectomies, the decision of the operation in our opinion being wise in order to be certain that the patient could be safely brought through the procedure of getting out enough thyroid tissue. The remaining two are cases in which the final hemithyroidectomy is to be done shortly.

There were two cases of tetany of short duration this year and, strangely, none in the cases previous to this year, considerably over five hundred in number.

There were five cases of malignancy this year and all are dead with the exception of one recent case in which a specimen was removed for pathological report. This measure we consider wise unless clinically there is no doubt whatever as to the malignancy, as we have had three cases of the so-called woody thyroids in which the consistency of the thyroid has been very similar to that of malignant thyroids but has not proved to be malignant on microscopic examination.

We have operated upon one lingual thyroid and in a baby five months old, one large colloid goitre causing pressure.

The total number of deaths has been four—one from thyroidism following ligation of one pole; one from probable cardiac failure in a patient with a past history of cardiac decompensation and with several attacks of auricular fibrillation, upon whom a hemithyroidectomy was done, both poles having been previously ligated; one from pneumonia following the removal of a large intrathoracic and posttracheal goitre; and one of unknown cause in a woman of fifty, strong and well, with non-toxic adenomata, operated in the students' clinic under ether.

In conclusion, while we are fairly well satisfied with this year's mortality rate, 1.28%, we feel that it should be reduced still further, having in mind, however, that mortality in a clinic such as ours, where patients with very serious thyroid lesions are being constantly presented to us, cannot be eliminated without refusing patients of this group.

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R. I. Ophthalmological and Otological Society—2d Thursday—October, December, February, April and Annual at call of President Dr. C. J. Astle, President; Dr. J. L. Dowling, Secretary-Treasurer.

The R. I. Medico-Legal Society—4th Thursday—January, April, July and October. Dr. Roswell S. Wilcox, President; Dr. H. S. Flynn, Secretary-Treasurer.

EDITORIALS

OUR ADVERTISERS.

The time-honored phrase that "It pays to advertise" is abundantly evidenced by the expressions of satisfaction voiced by many of our advertisers; while this may well be considered an asset in efficiency, we must continue to merit this appreciation.

In the language of a great American, "It is our plain duty" to patronize those who help to support our JOURNAL.

Not to do so is an evasion of what is expected of us.

The fact that this one or that one is not reached quite so handily may be advanced as a specie of explanation, but it does not rise to the dignity of an excuse.

We make every effort to know that our advertisers are of integrity and worthy of our confidence; manifest to them, therefore, your consideration in a tangible way.

AN EPIDEMIC OF HEALTH.

At the present time the world—or certainly that part within the boundaries of this State—is passing through an epidemic of health. It is evident in the rank and file of the profession and even shows itself in the dry field of vital statistics. What is the reason for this condition?

Some claim that the severe epidemic of 1918 attacked such a large proportion of the population that those who escaped the disease were naturally immune to all respiratory diseases and those who survived an attack gained an active immunity as the result. If this is so, the prospects for the physician in the future are not bright, because it will take almost a generation to build up a race of susceptible victims.

Still others claim that it is an evidence of the conservation of nature. The great war depopulated the world to such a degree that nature must do something to counteract this loss and so certain diseases have declared an armistice to help nature in her effort at armistice.

It is very doubtful whether these reasons and others that have been advanced successfully explain the unusual healthful conditions. Can we not, as a profession, claim some credit for this state of affairs? Surely the emphasis in the last few years has been on the prevention of disease—in the medical schools, in the various organizations doing research work, in the medical journals and even in the popular magazines. It must be that the work is beginning to show results. If this is the true explanation of the present epidemic of health, it illustrates the truth of the remark made by former President Eliot of Harvard to the effect that the medical profession was the only learned profession that was striving to eliminate itself.

EXPANDED LYING-IN SERVICE FOR PROVIDENCE.

Providence is fortunate in possessing an efficient Lying-in Hospital. Handicapped by not possessing the modern buildings and equipment which the hospital deserves, by reason of the high grade of its personnel and management it is doing excellent work. The results of treatment compare favorably with those of the best lying-in hospitals of the country. It is not generally realized that this hospital is one of the largest in the country. During 1920 there were 1,175 admissions and 1,078 babies were born. During the year 1920 there were admitted to the Boston Lying-in Hospital 1,123 mothers and 977 babies were born.

But there is one service which the Providence Lying-in Hospital does not furnish and a field of work which it should enter; the supervision and delivery of mothers of poor families who do not care to go to the hospital or who for some reason cannot. The midwife has been taking care of a large number of cases of this kind, particularly among the foreign-born. The midwife has served a useful purpose among the poor in many foreign countries but they are not capable of furnishing the skill nor obtaining the same results as a skilled physician. This includes not only the saving of infants' and mothers' lives but also the better treatment of parturition accidents so that the mother may be put back upon her feet in as sound a condition as before confinement. The midwife should not be a fixture in this country, but something must be supplied to take her place. That something is an out-patient and home service provided by lying-in hospitals. The number of in-patients of the Providence Lying-in Hospital and those of Boston Lying-in Hospital are about equal; in the latter 2,799 patients made 7,488 visits to prenatal clinics and 1,255 patients were attended by confinement in their homes.

The Providence Lying-in Hospital has made a beginning. In 1920, 793 patients visited the prenatal clinics but none were attended in their homes. The hospital should take up this work. In the near future the hospital will probably be moved to more extensive and modern buildings and this would be the proper time to make a beginning.

The function of the prenatal clinic should not only be to examine all mothers who expect to enter the lying-in hospital (unless they are private patients), but also to examine before and after delivery as many mothers as properly should go to the clinic. Many of these mothers may be able to pay a delivery fee to a private practitioner and the clinic should turn over to that physician all its information. This includes a class who should have supervision during pregnancy and afterwards and who are not able to pay for it, although they may be able to pay for the delivery alone.

There is another class who are really poor and who cannot afford to pay the fee which physicians

charge and many such turn to the midwife. This is the class which the lying-in hospital should attend in their homes.

The out-patient service should be supplied by a house officer and under the district and pupil nurses' supervision. The interne should have this as part of his service after he has served in the "house." It is much better then, for his previous experience makes it possible for him to go into private homes with reasonable assurance that he will be able to meet all ordinary conditions and know when to call for help. The home supervision should be a joint service between the hospital and the District Nursing Association. The pupil nurses in training should also have this work as part of their course. The house officer who has had his "house" experience and a nurse should be called for every home confinement which properly belongs to the hospital. In this way life will be saved and much damage to mothers avoided, while physicians and nurses will be provided with excellent opportunity to gain experience in midwifery as it has to be carried out in the home.

DR. G. ALDER BLUMER.

It is the privilege of THE JOURNAL to extend to Dr. Blumer the congratulations and good wishes of the medical profession of Rhode Island. Congratulations, not on his retirement from a post which twenty-two years of fruitful work must have rendered dear to him, but rather on those very twenty-two years of accomplishment. When a man has traveled such a road, and when he decides to pass on the burden of the continuation of his work to others, it is well that he should feel the satisfaction that comes from the knowledge that his achievements are appreciated by his colleagues and his community.

The past twenty-two years during which Dr. Blumer has been Superintendent of the Butler Hospital have seen many and far-reaching changes in the care of the mentally unfit. It is pleasant to reflect that Dr. Blumer himself has had such a large part in the working out of these advances. In no field can intelligent and altruistic humanitarianism better be displayed. Dr. Blumer was among the first to grasp and develop the modern conception of the care of the insane and it must be admitted that no better example of the practical application of these ideas can be found, than the work in his wards at the Butler Hospital. Twenty-two years ago last September Dr. Blumer left the Utica State Hospital, where he had served as assistant superintendent and superintendent after leaving the German Hospital, Philadelphia, in 1886. His undergraduate medical training he received at the University of Pennsylvania and his scholastic and collegiate work in his native country, England, as well as in France and Germany. The broad intellectual culture that he has achieved, that precious combination of science and the humanities, so rare among medical men and at the same time so valuable in all professional life and, above all, in the field of pschiatry, bears eloquent testimony to a life of study.

General acknowledgment of his attainments has been accorded him not only in the form of honorary university degrees but also in the opportunity to serve on occasions as pschiatrist under conditions of country-wide publicity. While extending to Dr. Blumer our best wishes for the future, we wish, turning to the past, to congratulate not only the doctor himself but also the hospital where he has labored and the city and state to which he has been an ornament.

PROBLEMS OF PUBLICATION BY AN EX-EDITOR.

To paraphrase "The Pirates of Penzance," the editor's lot is not a happy one. On him rests the responsibility of collecting a copy for each issue and for all the various processes of editing and proofreading until the copy has gone to the printer for publication. The editor of a medical journal has no paid assistants or reporters who are required to furnish material or else lose their jobs. He must rely upon the good will of his confreres to hand in promptly papers read before medical societies. These original articles are absolutely necessary to the conduct of the *Journal*. They form the essential ground work of each issue and the editorials, reports of societies and miscellany are only incidental items not absolutely essential to publication.

We feel that there is a definite need for the RHODE ISLAND MEDICAL JOURNAL in this State. It fills a place not covered by any other medical journal, and during the war, when publication was

necessarily suspended, the lack of it was plainly apparent.

Oftentimes when the editor presses his request for some article which has been read before a society and has not been handed in to the Secretary, he is made to feel that his request is an unjust one. Far from it. The By-Laws of our societies clearly state that papers read before them are the property of the society and are to be published in the transactions. The transactions in this State are, at the present time, published in the RHODE ISLAND MEDICAL JOURNAL. The same argument for promptness holds good with the associate editors who furnish articles, editorials, and new items which provide material for each issue. It is an easy matter to forget to hand in a copy for a definite date, but the failure to do so throws an extra burden upon the editor.

No one can appreciate the petty annoyances which help to make the editor's life an unhappy one unless he has himself held the position. We should all give our hearty support to the editor and coöperate with him in his thankless task. It is a modest request which he makes of us, and one which we may all carry out with no great burden to our brains or pens. If the RHODE ISLAND MEDICAL JOURNAL is worth supporting at all, it is worth supporting well.

CASE REPORT

REPORT OF A CASE OF TRAUMATIC RUPTURE OF URINARY BLADDER.

BY ARTHUR T. JONES, M. D., F. A. C. S.,
Providence, R. I.

The patient, Ethel C., aged fifteen years, white, was brought into the Memorial Hospital, October 13, 1921, having been run over by an automobile.

Upon admission patient is in extreme shock; abdomen tympanitic and tender throughout, especially over pubes; area of dullness over bladder. Abrasions of skin over lower abdomen. No other external evidences of injury. The patient was put to bed to await recovery from extreme shock. A catheterized specimen showed apparently clear blood. Pulse was 130. Diagnosis: Ruptured Bladder. After about four hours patient had sufficiently rallied from shock so that operation was done. Abdomen was opened, no blood found in peritoneal cavity; no evidence of rupture of viscera, or of fundus or posterior wall of bladder. There was much extravasation of blood into tissues on either side and in front of bladder and an active hemorrhage taking place beneath pubic arch in front of the bladder.

The abdominal peritoneum was closed and bladder opened extra-peritoneally. This revealed a laceration of the anterior bladder wall two inches in length and through which the fracture of the pubes and the separation of the bones could be felt. On the left side of the bladder was another laceration two and one-half inches long extending from base of bladder straight up the left wall. The anterior rent was sutured with Chromic gut. The patient's general condition was so poor at this time that she required stimulation and it was necessary to save all time possible. As no active bleeding was taking place from the tear in the lateral wall and as the edges came into good apposition, it was decided to establish drainage, control the hemorrhage, which was coming from the front of the bladder beneath the pubic arch with packings of gauze and to get the patient off the table as soon as possible. A self-retaining catheter was purse-stringed into the bladder through the abdominal incision, the hemorrhage beneath pubes controlled with gauze packing and incision closed down to the catheter and packing.

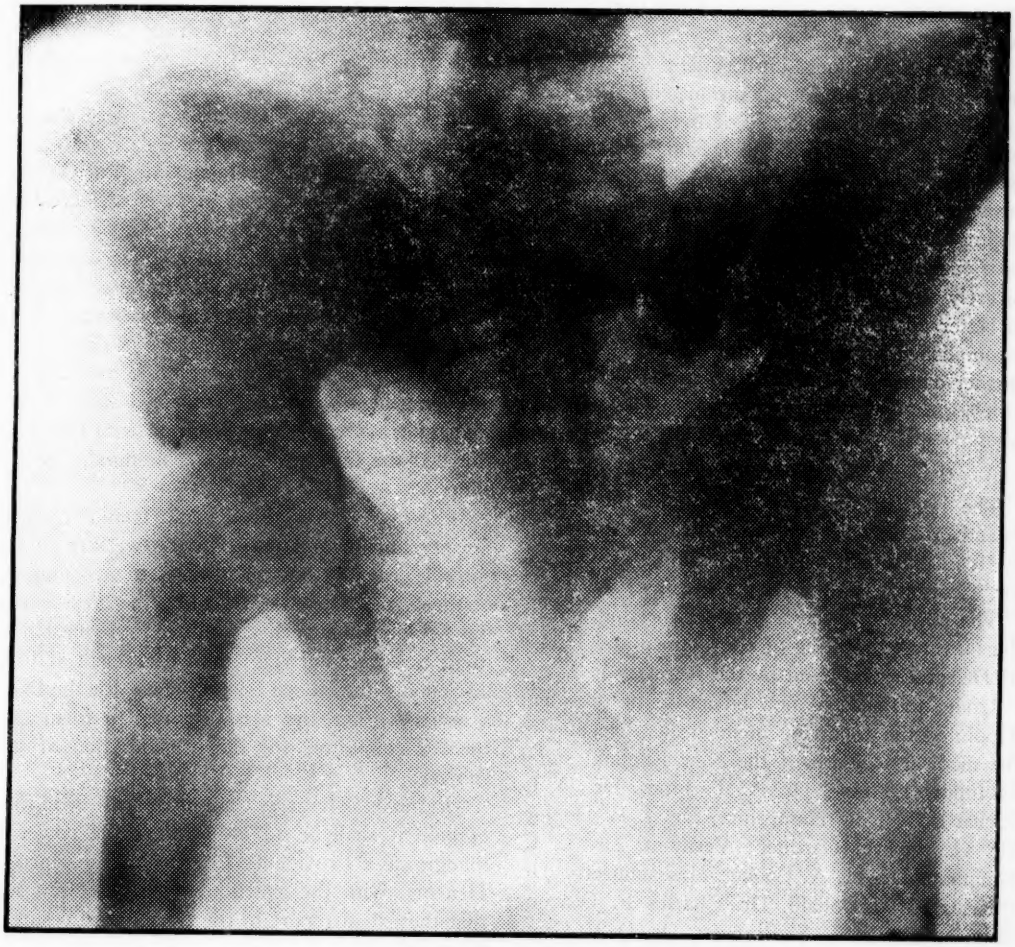
An X-ray of the pelvis shows a complete fracture of the horizontal portion of the left pubic bone; a fracture of ramus of the ischium and a fracture of the ilium straight down to the great sacrosciatic foramin.

The patient's condition was very poor when she left the table.

The following day, although general condition was poor, pulse weak, she gradually rallied. Drainage through the catheter, which was at first apparently clear blood, in twenty-four hours was showing very little blood and good amount of urine drainage. Forty-eight hours after operation patient was restless; sleeping in naps. On October 19 (thirty-seven days following operation), patient had shown steady improvement; drainage of urine through catheter. Gauze packing in the pre-vesical space was removed.

Patient has continued to make an uneventful recovery.

On November 6 soft catheter was passed into bladder through urethra. On November 9 patient



Fractured Pelvis with Rupture of Bladder
Ethel C.
Fracture Left Pubes, Ischium and Ilium

was voiding voluntarily. No leakage of bladder, the catheter having been removed on the twenty-first day. Patient was walking December 8 (fifty-six days following injury) without difficulty or pain and is to leave the hospital within a few days.

The interesting features of this case and the points which, in my opinion, tended particularly toward her recovery were:

Waiting a few hours until patient was over the primary shock; rapid operation; in fact, not spending time to suture one of the bladder tears, on account of extremely poor condition on the operation table; establishing constant drainage through self-retaining catheter and quickly controlling hemorrhage from the front of bladder with gauze packing; leaving the fractured pelvis severely alone, as any attempt at manipulation or to better position of bony structures would have accomplished very little at the time and tend to further damage of the soft structures.

SOCIETY MEETINGS

Rhode Island Medical Society.

The regular quarterly meeting of the Rhode Island Medical Society was held December 1, 1921, in the Medical Library building at 4 P. M. Dr. George S. Mathews, president, in the chair.

The minutes of the September meeting and of the November meeting of the Council and House of Delegates were read by the secretary.

Under the head of new business, the president appointed the following members as delegates to the medical societies of the New England states as follows: Maine, Dr. A. T. Jones, Dr. D. L. Richardson; New Hampshire, Dr. J. E. Donley, Dr. George W. Gardner; Vermont, Dr. L. C. Kingman, Dr. H. A. Cooke; Massachusetts, Dr. Charles A. McDonald, Dr. Charles F. Deacon; Connecticut, Dr. E. S. Brackett, Dr. D. F. Gray. He also appointed as member-at-large of the board of trustees of the Rhode Island Medical Library building, Dr. R. Morton Smith. He announced the anniversary chairman for the annual meeting and banquet to be Dr. J. E. Mowry.

The following program was presented: 1. A Study of Asthma, Dr. Jay Perkins, Providence. 2. Observations on Acute Appendicitis, Dr. Charles O. Cooke, Providence. 3. Diseases of the Thyroid and their Treatment, Dr. Frank H. Lahey, Boston. 4. Surgery in Diabetics, Dr. George W. Gardner, Providence. 5. What Can Be Done for the Deaf of Rhode Island? Dr. F. T. Rogers, Providence.

Following the reading of the last paper, Miss Marion Durfee, a teacher of lip reading, explained briefly the aims and possibilities of this form of education for the hard of hearing. Dr. Rogers demonstrated by two of Miss Durfee's pupils the degree of education possible to the deaf by lip reading, after which he proposed the following resolution, which was adopted:

"Whereas, The Rhode Island Medical Society, recognizing the fact that many cases of increasing deafness are not susceptible of relief by remedial measures, and, whereas adults afflicted with deafness are handicapped in their efforts to secure a livelihood, and children prevented from acquiring the education to which they are entitled, and,

"Whereas, The measures for the amelioration and betterment of this unfortunate class are inadequate and not at all commensurate with the relief afforded the tubercular, the feeble-minded or the blind,

"Resolved, That the Rhode Island Medical Society affirm its interest in the welfare of the chronic deaf by the appointment of a committee of three who are to be named by the president of the Society, and such committee is requested to invite a representative of the Department of Public Schools, the Rhode Island School for the Deaf, a social worker and Miss Durfee, to form with them a committee for the consideration of this subject.

"Resolved, That this committee shall, if in their opinion it shall be advisable, have the power to inaugurate a Providence League for the Hard of Hearing, with the sanction of this Society, and that they shall report to the Society the result of their action."

The chair appointed as committee, Dr. F. T. Rogers, Dr. N. D. Harvey, Dr. F. N. Bigelow.

Dr. William R. White spoke on Dr. Storrs, our oldest member, who sent a message of good wishes to the Fellows of the Society.

Adjourned.

Meeting of the Council.

The regular meeting of the Council was held November 22, 1921, 4:30 P. M., at the Medical

Library, the president, Dr. George S. Mathews, in the chair.

The application for transfer of membership of Dr. Roy Blosser from the Georgia Medical Society to the Rhode Island Medical Society was presented by the secretary with proper credentials from the former Society, and it was so voted that he be elected a member of this Society. In the absence of the treasurer, the secretary presented the treasurer's budget as follows:

Budget—1922.

Secretary expense	$ 75 00
Stenographer	30 00
Printing	75 00
Postage	50 00
Gas	60 00
Electricity	50 00
Fuel	500 00
Collations	500 00
Librarian	1,300 00
Books and Binding—including Ely Fund $74 for Journals	150 00
Janitor	396 00
Insurance	15 00
Safe Deposit	60 00
City Water	15 00
Telephone	75 00
House Supplies	50 00
House Repairs	150 00
Rhode Island Medical Journal	400 00
	$3,897 00

It was moved and seconded that a committee of two be appointed by the chair, with power to increase, as they may see fit, the total insurance on the building up to $30,000. An amendment was offered by Dr. Chase to the foregoing motion to permit the above committee to insure the contents of the building up to $10,000. The amendment, duly seconded, was passed, after which the original motion was adopted, the chair appointing Drs. S. A. Welch and A. T. Jones as committee.

It was then moved and seconded that the budget be recommended to the House of Delegates for adoption. It was so voted.

Adjourned.

J. W. Leech, *Secretary.*

Meeting of the House of Delegates.

The regular meeting of the House of Delegates was held November 22, 1921, at 5 P. M. in the Medical Library. The president, Dr. George S. Mathews, presided.

In view of the absence of the treasurer, Dr. W. A. Risk, for several months, the president called attention to the necessity of electing an acting treasurer. The name of the secretary, Dr. James W. Leech, was proposed as acting treasurer, seconded by Dr. F. N. Brown, and he was by vote declared acting treasurer until Dr. Risk returns. The treasurer's budget as recommended by the council was then adopted.

The following resolution, which was introduced at the September meeting of the Rhode Island Medical Society, was presented to the House of Delegates for definitive action:

"*Resolved,* That in the opinion of the Rhode Island Medical Society, it is apparent that sufficient funds have not been appropriated by the State Legislature for the medical care of the inmates of the State Hospital for Mental Diseases, and it is hereby urged upon the Legislature to make every effort to provide sufficient funds for the above purpose."

It was moved and seconded that the foregoing action be adopted. It was so voted.

Dr. Mowry moved that the secretary be instructed to forward a certified copy of the above resolution to each member of the finance committee of the House and Senate. Dr. A. T. Jones offered an amendment whereby the foregoing action should be forwarded to the newspapers for publication. This amendment was seconded and carried, after which the original motion was adopted. Dr. Brown, chairman of the committee on publication, tendered on behalf of Dr. Risk the latter's resignation from the committee on publication. It was moved that the resignation be accepted. Dr. B. H. Buxton, business manager, was elected a member of the committee on publication to take Dr. Risk's place.

Adjourned.

J. W. Leech, M. D., *Secretary.*

Woonsocket District Medical Society.

Regular monthly meeting of Woonsocket District Medical Society was held Thursday, November 17, at the office of Dr. W. C. Rocheleau, Hamlet Avenue. Dr. Charles P. Whelan of Boston gave a very interesting talk on "X-Ray Diagnosis and Treatment," after which a luncheon was served.

The next meeting of the Society will be held December 15.

HOSPITALS

NEWPORT HOSPITAL.

At the November meeting of the staff of the Newport Hospital after the reports of the departments were made, Dr. William A. Sherman of the surgical staff read a paper on Cæsarian section which was discussed by Drs. Stewart and Sullivan from the standpoint of operation and the indications.

At the December meeting of the staff of the Newport Hospital, the following officers were elected for the year of 1922: President, Dr. William A. Sherman; Vice-President, Dr. Edward V. Murphy; Secretary, Dr. Norman M. MacLeod; Librarian, Dr. D. P. A. Jacob.

PROVIDENCE CITY HOSPITAL.

On January 1, 1922, Dr. Arthur R. Newsam and Dr. Earl R. White finished services as internes. Dr. White is to begin private practice and Dr. Newsam to become house officer at the Children's Hospital, Boston. On the same date Dr. B. H. Davison and Dr. C. W. Fulbright began a six months' service as house officers.

Dr. Parker Mills, second assistant superintendent, has resigned to begin private practice in January, specializing in genito-urinary diseases. Dr. Mills has been assistant superintendent since April, 1918.

Dr. William Holt, now third assistant superintendent, will be promoted to the vacancy created by the resignation of Dr. Mills.

Contagious diseases continue to be very light. There are some diphtheria patients, a very few scarlet fever patients and no measles. There has never been so few patients suffering from these diseases under treatment at this time of year since the hospital was opened.

The regular monthly meeting of the Staff Association was held at the hospital on December 21st.

RHODE ISLAND HOSPITAL.

The annual meeting of the Staff Association was held at the Hospital Monday, December 12th, at 12 o'clock noon. Routine business was transacted, including the election of officers and selecting services.

Dr. James F. Boyd, now identified with X-ray Department, will open offices January 1, 1922, at 116 Waterman Street, for private practice, limited to X-ray work and radium therapy.

ST. JOSEPH'S HOSPITAL.

A meeting of the staff of St. Joseph's Hospital, at which election of officers was held at the outpatient building, Plenty Street, on December 9, 1921, at 9 P. M. The nominations for officers of the staff for the ensuing year were: President, Dr. John B. McKenna, and for Secretary, Dr. George F. Johnson.

The American Society for the Control of Cancer has asked St. Joseph's Hospital to co-operate with it in its effort at education. To this end a clinic is desired.

The executive committee of the staff, therefore asks that each member of the staff submit an outline report of the cases under his care or observation, treated or untreated, operable or inoperable, unoperated or recurrent, for review and selection, that it may be determined whether sufficient material is available for an instructive clinic.

GEORGE F. JOHNSON, *Secretary.*

MISCELLANEOUS

QUESTIONNAIRE ON ALCOHOL AS A THERAPEUTIC AGENT.

Various statements have been made as to the views of the medical profession on the therapeutic value of alcohol, whether whisky, beer or wine. The profession is quoted both as being in favor of and opposed to its use. So far as we know, no attempt has been made to ascertain the opinions of any considerable number of physicians on this question. In order to secure the views of a representative cross-section of the medical profession, a referendum is being taken this week. The questionnaire* has been carefully prepared, so that each physician can express his opinion on the important points in connection with the whole proposition. It is sent to forty thousand physicians—every other name on our mailing list. This list includes Fellows of the Association, members of the organization, and non-members. In addition, it is sent to ten thousand physicians who are neither members of the organization nor subscribers to THE JOURNAL, selected in a similar manner from the A. M. A. Directory. These lists

cover the whole country. A study of the questions will show that they are not leading and cannot influence in any way the opinion of the physician who replies. This referendum is of the utmost importance, and it is sincerely hoped that every physician who receives the questionnaire will immediately give it his careful consideration. It is the duty of every physician who receives this questionnaire to express his opinion.—*Jour. A. M. A.*, December 3, 1921.

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*Questionnaire on Alcohol as a Therapeutic Agent.

1. In what line of practice are you engaged? General practice?..... Specialty?.....
(State Specialty)
2. (a) Do you regard whisky as a necessary therapeutic agent in the practice of medicine? Yes [ ] No [ ]
[By "whisky" is meant distilled liquors, whether whisky, brandy, gin, or rum.]
(b) If "yes," in what diseases or conditions do you regard whisky as necessary?
3. (a) Do you regard beer as a necessary therapeutic agent in the practice of medicine? Yes [ ] No [ ]
[By "beer" is meant beer with the same alcoholic content as prevailed before prohibition went into effect, also ale, stout, porter, etc.]
(b) If "yes," in what diseases or conditions do you regard beer as necessary?
4. (a) Do you regard wine as a necessary therapeutic agent in the practice of medicine? Yes [ ] No [ ]
(b) If "yes," in what diseases or conditions do you regard wine as necessary?
5. (a) Have instances occurred in your own practice in which unnecessary suffering or death has resulted from the enforcement of prohibition laws? Yes [ ] No [ ]
(b) If "yes," how many such cases have you known in the last year?.....
6. How many times have you found it advisable to prescribe these liquors in a month?
Whisky..... Beer..... Wine.....
7. Is the prescribing of alcoholic liquors forbidden by your state law? Yes [ ] No [ ]
If "no," do you hold a federal permit? Yes [ ] No [ ]
8. (a) The present regulations limit the number of prescriptions to 100 in three months. In your opinion, should there be any limit to the number of prescriptions for alcoholic liquors a physician may write? Yes [ ] No [ ]
(b) If "yes," what should the limit be?
9. (a) In your opinion, should physicians be restricted in prescribing whisky, beer and wine? Yes [ ] No [ ]
(b) If "yes," what restrictions should be made?

.....M. D.

.....
(Postoffice Address) (State)

Please sign your reply, not for publication, but in order that we may know that it was filled out by a qualified physician. If you do not care to answer the questions, kindly return this questionnaire, with or without your signature. Return to American Medical Association, 535 N. Dearborn St., Chicago, Ill.

[Foot Note.—There have appeared in public print at divers times so many misleading and often false statements attributed to the medical profession, individually and collectively, as to their attitude toward the use of alcohol, that it has become the *duty* of all physicians to reply to this questionnaire, if for no other reason than that the authenticity of statistics shall be beyond quibble. If necessary, the above may be clipped out and returned (as per direction thereon) in lieu of the larger form. Make your X within the bracket.—Ed.]

ANNOUNCEMENTS

National Board of Medical Examiners.
1310 Medical Arts Building, Philadelphia.
December 8, 1921.

The first examination of the National Board, under the new plan, in Parts I and II, will be held as follows:

Part I, February 15, 16 and 17, 1922, inclusive.
Part II, February 20 and 21, 1922, inclusive.

Applications for examination should be received no later than January 15, 1922. Application blanks and circulars of information may be had by writing to the secretary, Dr. J. S. Rodman, 1310 Medical Arts Building, Philadelphia, Pa.

Fisk Fund Essay.

Annual meeting of the trustees was held in June. Several essays offered. There was no

award. Subject for 1921-1922, "Radium Therapy."

ETHER AND LAVENDER

JUST ROCKS.

An Off-Side, Non-Medical "Pome," Dedicated in Deep Sympathy to Those Who Know.

With face awry and saddened eye
And long and cold his days,—
There is no cheer, but a look of fear
In the face that quite dismays.
As he wanders by, we ask him why
The "Iron is in his soul."
He answers terse; yea, with a curse,
" 'Tis the Rocks they sell for Coal."

(And then he waxes wroth)

"They dumped in my empty bin,
And this advice I got:
'It's hard to beat this stuff for heat,
If you only keep it hot.'
And there you be, By Gum!" sezhe
"That money's good as stole
For it's buried deep in that great heap
Of Rocks they sell for Coal."

"Tho' we may rage at the miner's wage
That can't be all the cause,
The men that sell should be in—cell
But they seem above the laws.
Think of the price and the mighty slice
It takes from a feller's roll;
I'd not bewail if they stayed in jail
With the rocks they sell for Coal."

—*Umber.*

ABSTRACTS

ENDOCRINOLOGY.

The mere fact that hundreds of physicians and thousands of patients have testified to having profited by the use of this or that endocrine preparation, R. G. HOSKINS, Columbus, Ohio (*Journal A. M. A.*, November 5, 1921) says, carries no conviction of its actual value to one who reflects that the pharmacopeias are filled with useless medicaments of which the same can be said. Reports of cures are convincing only when accompanied by adequate evidence that suggestion and other accessory therapeutic measures, as well as mere coincidence, have been ruled out as the determining factors. So long as practitioners fail to realize the essential requirements of scientific evidence and to educate their patients along this line, not only pseudo-endocrinology but also a multitude of other pseudoscientific cults will continue to flourish. The outstanding fact is that endocrine physiology is largely in a state of uncertainty, whereas the facile applied endocrinology with which we are so unfortunately familiar assumes a large body of substantiated fact. Deductive reasoning, which is the mainstay of a considerable class of self-styled practical endocrinologists, can be productive only when the premises are sound. However probable the existence of numerous circulating hormones, proof of their existence is almost completely lacking. The existence of hormonic antagonism remains yet to be proved, however fascinating it is to theorize about. A fantastic theory that has had some currency is that the body cells have a capacity to select from a pluriglandular mixture any hormones they happen to need and to discard the rest. All the evidence is to the contrary. Both clinically and experimentally it is sufficiently plain that the law of mass action has not yet been repealed. To deduce from the unfortunate existing situation, however, the conclusion, which certain shallow observers seem to have drawn, that the field of endocrinology itself is merely a mirage, is quite as crass a mistake as to accept as substance every flattering prospect the eye discerns. Endocrinology is one of the most difficult fields of biology. The problems presented are fundamental and quite as fascinating as can be found in any field. There is no easy road in endocrinology, either to discovery or to knowledge already gleaned. There are many problems demanding solution, which require, not genius, but merely accuracy and patience together with recognition of the ordinary criteria of evidence in any field. What is needed is more work, carefully planned and carried out, less shallow theorizing on the part of those dabbling with the problems, and the consistent but discriminating support of the medical profession.—*Abstract from the J. A. M. A.*